DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 2

2. STATE: South Dakota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, page 2, 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, page 2

10. SUBJECT OF AMENDMENT: To amend the reimbursement methodology for Federally Qualified Health Centers and Rural Health Clinics from a reasonable cost-based method to a prospective payment system, as required by the Benefits Improvement and Protection Act of 2000.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
James W. Ellenbecker

13. TYPED NAME:
James W. Ellenbecker

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 29, 2001

16. RETURN TO:
Department of Social Services
Office of Medical Services
700 Governor's Drive
Pierre, SD 57501-2291

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
April 2, 2001

18. DATE APPROVED:
6/26/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/01/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
David R. Selleck

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: March 30, 2001

2b. Rural Health Clinics

Payment for Rural Health Clinic services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All covered Rural Health Clinic services furnished on or after January 1, 2001 and each succeeding fiscal year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse RHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

Payment is set prospectively using the RHC's reasonable costs (the lower of the average per cost visit from RHC cost reports or the Medicare RHC upper payment limit per visit, as established under the existing methodology) of providing Medicaid-covered services during RHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during RHC fiscal year 2001.

The baseline per visit rate is determined for each RHC by (1) calculating a per visit rate for RHC Fiscal Year 1999 and RHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two. The RHC per visit rate is inflated forward from the endpoint of RHC Fiscal Year 1999 to the midpoint of State Fiscal Year 2001.

Beginning in Federal fiscal year 2002 (October 1, 2001), and for each calendar year thereafter, the per visit payment rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the RHC during that fiscal year. The RHC will be responsible for supplying the needed documentation to the State for any adjustments required as a result of any increase or decrease in the scope of services. The Medicare cost report must be provided to the State within 150 days from the provider's fiscal year end to be considered in calculation of the rate.

The MEI will be applied January 1st of each year.

For newly qualified RHCs after Federal fiscal year 2000, initial payments are determined by the statewide average per visit rate, updated each year using the MEI. A prospective rate shall be calculated after the provider has submitted a cost report for two full RHC fiscal years, according to the methodology described above.

2c. Federal Qualified Health Centers

Payment for Federally Qualified Health Center services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All covered Federally Qualified Health Center services furnished on or after January 1, 2001 and each succeeding fiscal year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse FQHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

Payment is set prospectively using the FQHC's reasonable costs of providing Medicaid-covered services during FQHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during FQHC fiscal year 2001.

The baseline per visit rate is determined for each FQHC by (1) calculating a per visit rate for FQHC Fiscal Year 1999 and FQHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two. The FQHC per visit rate is inflated forward from the endpoint of FQHC Fiscal Year 1999 to the midpoint of State Fiscal Year 2001.

Beginning in Federal fiscal year 2002 (October 1, 2001), and for each calendar year thereafter, the per visit payment rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the FQHC during that fiscal year. The FQHC will be responsible for supplying the needed documentation to the State for any adjustments required as a result of any increase or decrease in the scope of services. The Medicare cost report must be provided to the State within 150 days from the provider's fiscal year end to be considered in calculation of the rate.

The MEI will be applied January 1st of each year.

For newly qualified FQHCs after Federal fiscal year 2000, initial payments are determined by the statewide average per visit rate, updated each year using the MEI. A prospective rate shall be calculated after the provider has submitted a cost report for two full FQHC fiscal years, according to the methodology described above.

3. Other Lab and X-Ray

See physician services - section 5 of this attachment.

4. Specialized Surgical Hospitals

Specialized Surgical Hospitals will be reimbursed on the same basis as ambulatory surgical centers, as determined by the department, for outpatient services.